MONTANA CANCER CONTROL PROGRAMS

Colorectal Screening Form

MONTANA Department of Public Health & Human Services

Last Name	First Name	Middle Initial	Birth Date	Admin Site #
			MM / DD / YYYY	

Social Security Number	Phone Number	State ID
- -		

Date initial test scheduled or fecal kit distributed
Date MM / DD / YYYY

Screening adherence
☐ Not done, FOBT/FIT kit not returned ☐ Not done, appointment not kept.

Take Home Test :
☐ FOBT ☐ FIT

Date of result MM / DD / YYYY

Indication for test
☐ Screening

Result
☐ Negative
☐ Positive
☐ Pending
☐ Unknown

Outcome
☐ Complete
☐ Incomplete/Inadequate
If Incomplete/inadequate, reason: _____

Take Home Test FOBT or FIT Section

Provider specialty
☐ General Practitioner ☐ Internist ☐ Family Practitioner
☐ Gastroenterologist ☐ General Surgeon ☐ Radiologist
☐ Colorectal Surgeon ☐ Physician Assistant ☐ OB/Gyn
☐ Registered Nurse ☐ Licensed Practical Nurse ☐ Nurse Practitioner

Next test recommended in this cycle
☐ Colonoscopy ☐ Sigmoidoscopy
☐ DCBE ☐ Surgery to complete diagnosis
☐ None, cycle complete ☐ Other _____

Procedure Performed:
☐ Colonoscopy ☐ DCBE

Procedure Date MM / DD / YYYY

Indication for test
☐ Screening ☐ Surveillance ☐ Diagnostic

Result
☐ Normal/negative/diverticulitis/hemorrhoids
☐ Other findings, not suggestive of cancer/polyps
☐ Polyps/suspicious for cancer/presumed cancer
☐ Inadequate/Incomplete test with no findings
☐ Pending

Outcome
☐ Complete ☐ Incomplete/Inadequate

Was a biopsy/polypectomy performed during the endoscopy? ☐ Yes ☐ No
If Yes, complete the Colorectal Endoscopy Section II Form.

Endoscopy Section I

Provider specialty
☐ General Practitioner ☐ Internist ☐ Family Practitioner
☐ Gastroenterologist ☐ General Surgeon ☐ Radiologist
☐ Colorectal Surgeon ☐ Physician Assistant ☐ OB/Gyn
☐ Registered Nurse ☐ Licensed Practical Nurse ☐ Nurse Practitioner

Adequate bowel preparation to detect polyps greater than 5mm. (decided by the endoscopist) ☐ Yes ☐ No ☐ Unknown

Was the cecum reached during this colonoscopy?
☐ Yes ☐ No ☐ Unknown
If No, was the splenic flexure reached? ☐ Yes ☐ No

Were there any complications? ☐ Yes ☐ No
If Yes, complete the Colorectal Endoscopy Section II Form.

Next test recommended in this cycle
☐ Colonoscopy ☐Sigmoidoscopy
☐ DCBE ☐ Surgery to complete diagnosis
☐ None, cycle complete ☐ Other _____

Status of Final Diagnosis
☐ Complete
☐ Pending
☐ Refused diagnostic follow-up
☐ Lost to follow-up before final diagnosis

Date of final diagnosis, refused, or lost to follow up
MM / DD / YYYY

Final Diagnosis
☐ Normal/Negative
☐ Hyperplastic polyps
☐ Adenomatous polyp, no high grade dysplasia
☐ Adenomatous polyp, with high grade dysplasia
☐ Cancer

Recurrent Cancers
☐ New colorectal cancer, primary
☐ Recurrent colorectal cancer
☐ Non colorectal cancer primary (metastasis from another organ)
☐ Unknown

Recommended screening or surveillance test for next cycle
☐ Take home FOBT ☐ Take home FIT
☐ Colonoscopy ☐ Sigmoidoscopy
☐ DCBE ☐ None

Number of months before screening or surveillance test for next cycle.
(If none, leave blank) _____

Indication for screening or surveillance test for next cycle
☐ Screening ☐ Surveillance after a positive colonoscopy and/or surgery

If client has a polypectomy, biopsy, surgery or complications, complete the Colorectal Endoscopy Section II Form.

Provider Signature _____ **Provider Name** _____

MONTANA CANCER CONTROL PROGRAMS

Colorectal Endoscopy Section II Form

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Last Name	First Name	Middle Initial	Birth Date	Admin Site #
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Histology of most severe polyp/lesion
(*Complete if biopsy/polypectomy was done during the colonoscopy)*
- ☐ Normal or other non-polyp histology
- ☐ Non-adenomatous polyp (inflammatory, hamartomatous, etc.)
- ☐ Hyperplastic polyp
- ☐ Adenoma, NOS (no high grade dysplasia noted)
- ☐ Adenoma, tubular (no high grade dysplasia noted)
- ☐ Adenoma, mixed tubular villous (no high grade dysplasia noted)
- ☐ Adenoma, villous (no high grade dysplasia noted))
- ☐ Adenoma, serrated (no high grade dysplasia noted)
- ☐ Adenoma with high grade dysplasia (includes in situ carcinoma)
- ☐ Adenocarcinoma, invasive
- ☐ Cancer, other
- ☐ Unknown/other lesions ablated, not retrieved or confirmed

Number of adenomatous polyps/lesions
(Complete if result of the histology is Adenoma or Cancer)
- ☐ Less than 97…..Enter the number _____
- ☐ 97 or more adenomatous polyps/lesions
- ☐ At least one adenomatous polyps/lesions, exact number not known
- ☐ Unknown

Size of largest adenomatous polyp/lesion
(Complete if result of the histology is Adenoma or Cancer)
- ☐ Less than 1 cm……. Enter the size _____
- ☐ Greater than 1 cm …Enter the size _____
- ☐ Between 1 cm and 2 cm ☐ Between 2 cm and 3 cm
- ☐ Between 3 cm and 4 cm ☐ Between 4 cm and 5 cm
- ☐ Microscopic focus ☐ Diffuse
- ☐ Unknown (size not stated)

Histology from surgical resection
(*Complete if surgery was performed to complete diagnosis.)*
- ☐ Surgery recommended but not performed
- ☐ Normal or other non-polyp histology
- ☐ Non-adenomatous polyp (inflammatory, hamartomatous, etc.)
- ☐ Hyperplastic polyp
- ☐ Adenoma, NOS (no high grade dysplasia noted)
- ☐ Adenoma, tubular (no high grade dysplasia noted)
- ☐ Adenoma, mixed tubular villous (no high grade dysplasia noted)
- ☐ Adenoma, villous (no high grade dysplasia noted))
- ☐ Adenoma, serrated (no high grade dysplasia noted)
- ☐ Adenoma with high grade dysplasia (includes in situ carcinoma)
- ☐ Adenocarcinoma, invasive
- ☐ Cancer, other
- ☐ Unknown/other lesions ablated, not retrieved or confirmed

Date surgery performed MM / DD / YYYY

Complications of endoscopy requiring observation or treatment.
(*Report the worst of up to 2 serious complications of CRC testing occurring within 30 days of the test date and resulting in an ER visit or hospitalization.)*
- ☐ No complications
- ☐ Bleeding, transfusion required
- ☐ Bleeding not requiring transfusion
- ☐ Cardiopulmonary events (hypotension, hypoxia, arrhythmia, etc)
- ☐ Complications related to anesthesia
- ☐ Bowel perforation
- ☐ Post-polypectomy syndrome/excessive abdominal pain
- ☐ Death
- ☐ Other _____

Print Provider's Name _____

Provider's Signature _____

Status of treatment (Complete if final diagnosis is Cancer)
- ☐ Started and/or completed
- ☐ Not indicated due to polypectomy
- ☐ Not recommended
- ☐ Refused
- ☐ Lost to follow-up
- ☐ Treatment pending

Date of treatment MM / DD / YYYY